AMERICAN STOP SMOKING INTERVENTION STUDY FOR CANCER PREVENTION (ASSIST)

RFP#: NCI-CN-95165-38

TECHNICAL PROPOSAL
ORIGINAL

Submitted By:

Maine Department of Human Services
Bureau of Health
State House Station 11
151 Capitol St.
Augusta, ME 04333
(207) 289 - 5180

This proposal is predicated upon all of the terms and conditions included in the Request for Proposals

Rudolph Naples

Rudolph Naples
Deputy Commissioner
Maine Department of Human Services

September 25, 1990

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ME 4

John R. McKernan, Jr.
Governor

Rollin Ives
Commissioner

STATE OF MAINE
DEPARTMENT OF HUMAN SERVICES
AUGUSTA, MAINE 04333

September 21, 1990

Barbara Mercer
Research Contracts Branch
National Cancer Institute
Executive Plaza South, Room 635
6120 Executive Boulevard
Rockville, Maryland 20852

Dear Ms. Mercer:

We are pleased to submit Maine's application for Project ASSIST, "RFP No. NCI-CN-95165-38." Packaged separately are the original plus twenty copies of the Technical Proposal in four boxes and the original plus twenty copies of the Business Proposal in one box.

Thank you for your consideration.

Sincerely yours,

Randy Schwartz

Randy Schwartz, MSPH
Director
Division of Health Promotion
and Education
Bureau of Health

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I. INTRODUCTION

I. INTRODUCTION

The Maine Department of Human Services, Bureau of Health, in conjunction with the American Cancer Society, Maine Division, Inc. is pleased to submit this proposal to implement the American Stop Smoking Intervention Study (ASSIST) for Cancer Prevention in Maine.

1.1 Why Fund Maine?

Maine is in an excellent position to successfully carry out this project because:

1. Maine has a record of commitment to reducing the morbidity, mortality and economic consequences of tobacco use exemplified by:

   - An active Coalition on Smoking OR Health, with the three major voluntary health associations - American Cancer Society, Maine Division, Inc.; American Lung Association of Maine; and American Heart Association, Maine Affiliate in conjunction with the Maine Medical Association and Maine Bureau of Health form the principals of the Coalition. Over 23 health-related organizations participate in the Coalition.

   - An impressive record of tobacco control legislation, rated extensive by the U.S. Office on Smoking and Health.

   - A Governor's Commission on Smoking OR Health, established by Executive Order of Governor John R. McKernan, Jr. in 1989 indicated commitment to tobacco prevention and control at the highest level of state government.

   - Excellent sources of data on a variety of tobacco use indicators.

2. The Maine Bureau of Health has a demonstrated record of commitment to public health interventions for chronic disease prevention and control:

   - Nationally recognized Diabetes Control Project.

   - One of seven states to implement NHLBI Hypertension Control Coordinating Project in early 1980's. A Cardiovascular Risk Reduction Program still exists as a result.

   - NCI Technical Assistance Grant 1986-1988.

   - Soon to begin NCI Data-based Intervention for Public Health Agencies project.

- CDC funded cooperative agreement for Community Chronic Disease (CVD & CA) Prevention Program.

- Active PATCH (Planned Approach to Community Health) Program.

- CDC funded Behavioral Risk Factor Surveillance System.

3. Maine's public health and health care community has a rich history of coalition-building for action for health.

   - Coalition on Smoking OR Health
   - Maine School Health Education Coalition
   - Adolescent Pregnancy Coalition
   - Consumers for Affordable Health Care Coalition
   - Project LEAN Maine Partners Network
   - Maine Prevention Network
   - Healthy Mothers, Healthy Babies Coalition

4. The Maine Legislature and private providers have a record of commitment to cancer control and other chronic disease prevention and control activities, by:

   - establishing and funding a Cancer Registry.
   - establishing and funding an Environmental Health Unit.
   - funding a community-based cardiovascular disease prevention program.
   - funding several positions in the Diabetes Control Project previously funded through a federal cooperative agreement.
   - passing nationally recognized tobacco control legislation.
   - establishing the Cancer Prevention and Control Advisory Committee.
   - establishing an Environmental Health Advisory Committee.
   - collaborating with a nationally known Maine physician, Robert McAfee, M.D., who is active with the American Medical Association's tobacco control efforts.

5. Proposed project staff are extremely well-qualified to carry out Project ASSIST activities in Maine:

   - Project Director, Randy Schwartz, MSPH, has extensive experience in community-based health promotion and chronic disease prevention as well as tobacco prevention and control.

   - Project Coordinator, Sandra Hoover, PhD, an anthropologist with a Masters of Public Health has extensive experience in community interventions, coalition building, and multi-cultural health activities.

- A subcontract with the University of Southern Maine enlists the services of Jan Hitchcock, PhD, nationally known smoking prevention researcher; Dr. Hitchcock is formerly the Associate Director of the Harvard University Institute for Smoking Behavior and Policy.

However, significant smoking control needs remain:

- Maine has the third highest prevalence of smokers age 18-34 in the U.S.
- Maine has the sixth highest smoking attributable mortality rate in the U.S.
- An active anti-smoking coalition has caught the attention of the tobacco industry which has begun a campaign of organizing so-called "smoker's rights" groups in Maine.

1.2 Maine

Maine can be described in a variety of ways - by geography, population, and climate. This description will be enhanced by the use of psychographic information recently made available, which provides an even broader understanding of Maine and its people.

In 1987, the Commission on Maine's Future was established by the Maine State Legislature "to recommend a desirable and feasible description of the state's future" (Commission on Maine's Future 1989). The Commission's forty members conducted polls, held public hearings and work sessions, and interviewed government, community and business leaders throughout Maine. The work of the Commission led to several publications in recent months which describe where Maine has been, where Maine is now, and what the state's people envision for the 21st Century.

A snapshot of where Maine is now reveals that:

- the population has grown steadily since the Great Depression;
- more people are arriving than are leaving;
- about half of the population lives in southern and central urban counties;
- the location of the Interstate Highway has greatly influenced the distribution of people;

- the economic vitality has led to growth in per capita income and employment that outpaced the national average in the late 1980s;

- a gradual shift of its workforce from goods-producing jobs to non-manufacturing jobs has occured;

- students tend to plan their education for specific, entry-level jobs instead of for life-long careers;

- substantial advances in improving air and water quality have been made since the 1970s;

- the natural characteristics that define rural areas are gradually eroding;

- four in five Mainers agree that the natural beauty should be preserved, even if it means spending more public money or interfering with private investment decisions.

1.2.1 Geography

With an area of 33,215 square miles, Maine is New England's largest state and almost equal in land area to the other five New England states combined. The state is 210 miles wide and 330 miles long. Maine is isolated from the rest of the country. It is the only state in the contiguous 48 that borders only one other state.

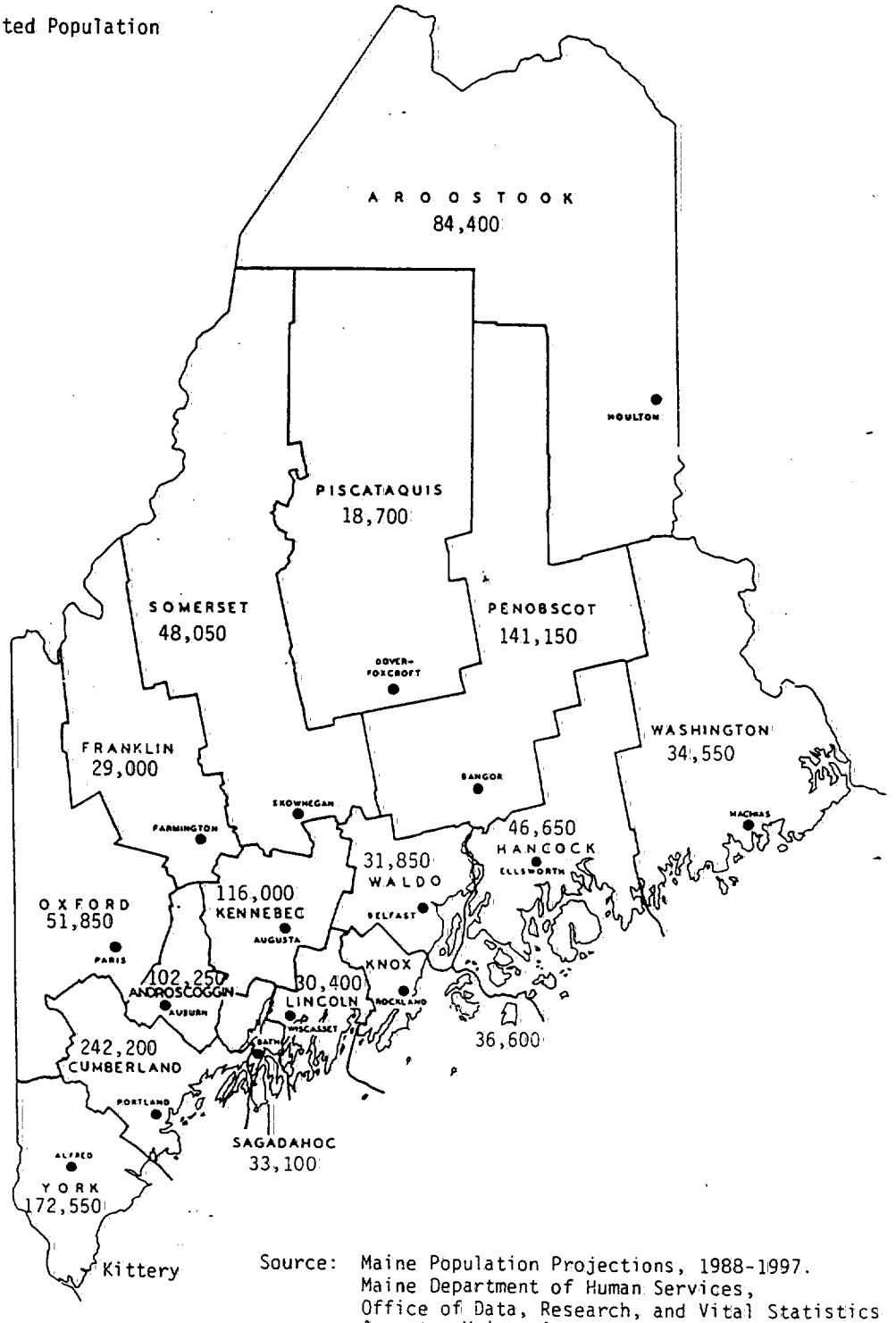
Maine is comprised of 16 counties, the most northern and largest of which is Aroostook with 6,453 square miles of land area (greater than the size of Rhode Island and Connecticut combined) (map on p.6). There are 22 cities, 424 towns, 51 plantations, and 416 unorganized townships. The wilderness and unorganized townships are located in Aroostook, Franklin, Piscataquis, and Washington counties.

Maine's geography is diverse, comprised of seacoast, mountains, and forested land; much of which is wilderness. The shoreline is the longest of any state on the East Coast, extending for about 3,500 miles. The straight-line distance along the coast is approximately 230 miles. Approximately 3,500 islands lie off the coast; only a handful are inhabited. The coastal region is dominated by sand beaches in the south and rocky headlands in the north.

Mountains and hills occur in many areas of the state. The highest peaks are in the western part. Mount Katahdin is the highest peak, with an elevation of 5,267 feet. Central Maine, too, has a number of mountains, including Sugarloaf Mountain at 4,237 feet (home of one of Maine's largest ski resorts). Fifty peaks are higher than 3,400 feet. Some of the most picturesque mountains are those on the coast,

MAINE – COUNTIES AND COUNTY SEATS

1990 Projected Population



Source: Maine Population Projections, 1988-1997.
Maine Department of Human Services,
Office of Data, Research, and Vital Statistics
Augusta, Maine, June 1989

including the Camden Hills and Cadillac Mountain, whose almost sheer rise from the ocean to 1,532 feet gives it the highest elevation on the Atlantic coast north of Rio de Janeiro in Brazil.

There are more than 5,000 rivers and streams, and more than 2,500 lakes and ponds. About one tenth of the state's area is water. Moosehead Lake, the largest, is 40 miles long and varies from two to ten miles wide, and is one of the country's largest bodies of fresh water lying entirely within the boundary of one state.

Seventeen million acres of Maine are forest, much of which is privately owned by paper companies. The majority of the forest growth is pine, spruce and fir interspersed with white birches and sap-bearing maple trees. There are one half million acres of state and national parks. Acadia National Park, located on the coast in Hancock County, draws about five million visitors annually, making it the second most visited national park in the United States.

Although Maine is considered to have a great deal of "wilderness," most of these areas are criss-crossed by roads used by the paper companies and cannot be considered true wilderness. The one-half million acres of publicly-owned land is a relatively small, when one considers how much of the state is not developed.

As was mentioned previously, the majority of Mainers are willing to spend more public dollars to preserve natural lands. Their commitment was displayed in a very tangible way. Maine's citizens moved to increase public lands by passing a bond issue in 1988 that authorized $35 million for the purchase of exceptional land for public use.

A number of large rivers dominate the landscape - the Androscoggin, the Kennebec, the Penobscot, the Allagash, the Saco and the St. John. These rivers have served and continue to serve multiple purposes in the lives of Maine people, such as sources of hydroelectric power generation, food, and in some cases public water, as well as logging and transportation routes, and pleasant sites for recreation.

1.2.2 Climate

The climate varies widely throughout Maine. Peak summer temperatures average 70 degrees Fahrenheit, although inland areas may experience temperatures as high as 90 degrees Fahrenheit or more during the summer months. Coastal temperatures are moderated in winter and summer by the ocean and do not reach the extremes of inland areas.

Winter is a long season in Maine with freezing weather beginning in November and snowfall frequently continuing into April. Prolonged winter cold spells are rare, but northern sections may experience as many as 40-60 days of subzero temperatures annually while coastal and southern areas may have 10-20 such days. Annual snow fall in Northern Maine is about seven feet, about five feet along the coast.

1.2.3 Population

Maine is the least densely populated state east of the Mississippi River. Until recently, the population was distributed in the southern counties and in a transportation corridor extending fifteen miles on either side of the Interstate 95 Highway system from Kittery in the south to Houlton in the north. However, the population center is shifting southward and toward the coast.

According to current estimates, the total population in 1990 is 1,219,300 people; 1988 figures showed that the population was 49% male and 51% female (Table I.E.1, in the Appendix). The greatest proportion of the population is in the young adult (25-34 years old) age group. Those in the 15 to 24 year old group represent the next largest percentage of the population. These statistics will be borne in mind when forming the ASSIST coalition. Non-whites comprise only a small proportion of the total population, approximately 1.5% according to 1988 data (Table I.E.2, in the Appendix). The vast majority of Maine's non-white population is Native American.

According to the 1980 U.S. Census of the population, 4,087 Native Americans reside in Maine. There are three reservations in Maine: Indian Island, Penobscot Indians (pop. 458), Perry and Princeton Townships (pop. 737 and 964 respectively) home to the Passamaquoddy tribe. These figures include a small number of non-Native Americans. Other major Native American populations are the Maliseet and Micmac tribes. No census figures are available for these grups specifically.

Just under 25% of the population is Franco-American. Next to New Hampshire, Maine has the highest percentage of first- and second-generation Franco-Americans in the country. Franco-Americans in Maine have maintained a strong ethnic identity. The group has tended to settle in the St. John River Valley in the north and in textile and paper mill towns throughout the state (including areas of Franklin County). The Franco-American community has been a leading force in the rebuilding of the Democratic party in the state. John Martin, current speaker of the Maine House of Representatives and President-Elect of the National Council of State Legislators is Franco-American.

Franco-Americanism has been preserved in Maine due to a number of factors, including proximity to and continued migration from French Canada; the absence of competing minorities; and a high birthrate in the early part of the century reinforced and expanded cultural identity. Early in the 1900s it was possible for Franco-Americans to pass an entire day without meeting an English-speaking person. Unfortunately, this ethnocentrism is accompanied by a relatively low standard of living. A survey conducted in the winter of 1960 in Lewiston and Brunswick found a high inverse correlation between ethnic involvement and income (Walker 1961). Although this information is quite dated, anecdotal evidence indicates the situation has not greatly changed.

In Maine, as in the nation, average household size has declined sharply in the past two decades, from 3.3 persons in 1960 to 2.6 persons in 1987. At the same time, however, the number of households in Maine has increased dramatically, due to divorce, baby boomers in the housing market, and increased numbers of elderly.

Regional growth has been concentrated in three counties in coastal southern Maine - York, Cumberland, and Sagadahoc. Localized growth spurts have occurred in the counties of Lincoln, Knox, and Hancock.

Population density in Maine is 39 people per square mile, although density rises to 64 people per square mile when unorganized territories are not included in the calculation.

1.2.4 Political Structure

Maine was incorporated as a state in 1820. Since then, the state has had a variable number of representatives to the United States House of Representatives. At present, Maine has two congressional districts. The First Congressional District now contains the counties of York, Cumberland, Sagadahoc, Lincoln, Knox, Kennebec, and part of Waldo, and is represented by Representative Joseph E. Brennan, a Democrat. The Second Congressional District covers the rest of the state from Porter in Oxford County to Fort Kent in Aroostook County. It is the largest Congressional District east of the Mississippi River. Representative Olympia J. Snowe represents the Second District; she is a Republican.

Maine's two United States Senators are George J. Mitchell and William S. Cohen. Senator Mitchell is a Democrat and Majority Leader of the Senate. Senator Cohen is a Republican.

Maine was once considered to be traditionally Republican; in fact, in 1940 Republican registration was 262,367 compared to 99,386 Democrats. In the decades since, Democratic registration has increased considerably, and the two major parties are now more comparable.

Within the state's executive branch, the only popularly elected official is the Governor. Governors may serve two four-year terms. The current governor, elected in 1986, is John R. McKernan, Jr., a Republican. The remaining constitutional state officers (the Attorney General, Secretary of State, Treasurer, and Auditor) are elected by the legislature.

There are 35 Senators and 151 Representatives within the two houses of the Maine Legislature. Each is elected for a two year term. The legislature has 19 standing committees from both houses which include Aging, Retirement and Veterans, Agriculture, Appropriations and Financial Affairs, Audit and Program Review, Banking and Insurance, Business Legislation, Education, Energy and Natural Resources, Fisheries and Wildlife, Housing and Economic Development, Human Resources, Judiciary, Labor, Legal Affairs, Marine Resources, State and Local Government, Taxation, Transportation, and Utilities.

County government, as elsewhere in New England, has weakened so that counties have few functions left (its very existence is currently being debated in the state legislature). These functions include the operation of jails, sheriffs departments, probate courts, and special facilities such as civic centers.

The state judicial system consists of the Maine Supreme Judicial Court, Superior Courts, and District Courts. The supreme court consists of a chief justice and six associate justices. Superior courts are served by 14 justices; district courts by 20 judges. Justices and judges are appointed by the governor for seven year terms.

1.2.5 Transportation

Because Maine is a large state with low population density, transportation is a major consideration. Much of the population is settled along the major highways, but those living in outlying areas may be extremely limited in access to many services. Limited interstate and in-state bus service is available, and some of the larger municipalities have small local bus lines.

1.2.6 Economy

Since 1940, Maine has changed from a mainly rural state to an increasingly urban one. The state's economy has changed from primary reliance on natural resources and assembly-line industries using cheap labor to a more diversified economic base including metals and machinery, defense industries, and the service sector.

In the 1980s, Maine underwent a period of sustained economic growth which continued unabated until 1988. Historically, the state, and particularly its rural areas, have had trouble finding enough jobs to employ all of its citizens. That situation was reversed in the 1980's, which produced a tight labor market, rising wages, and an economy which outpaced the national economy. However, not all counties shared equally in Maine's economic growth. The northernmost counties, Aroostook and Washington did not share in this growth; they lost population and still unemployment remained high, at times almost three times the rate of the state as a whole.

Manufacturing generates a little less than one-third of all economic activity in Maine and has for twenty years. However, the mix of products has changed dramatically from the traditional nondurable items such as shoes, paper, and textiles to durable goods - electronic equipment, for example.

The economy is more diversified than in the past, changing from the mill town economy with its dependence on a single large employer to a mix of light industry and business and consumer services. Between 1980 and 1988, more than 100,000 new jobs were created in Maine. These jobs are primarily service sector. There was a decrease of 14,000 jobs between 1989 and 1990.

1.2.7 Labor Pool

The labor pool, those aged 18 to 64, is projected to increase by 17 percent between 1986 and 2010. Seven in ten adult women under age 65 were in the labor force in 1988, according to a poll by the Commission on Maine's Future (1989). After age 65, more than a sixth of the women continued to work.

In contrast, the poll found that an unprecedented proportion of men have chosen to retire early. One man in five between the ages of 50 and 64 was retired and out of the workforce in 1988. Three-quarters of the men in this age group worked; 97 percent of those aged 35-49 worked as did 90 percent of those aged 18-34. In spite of the movement of women and the return of the elderly into the labor market, Maine continues to have the smallest proportion of its population in the labor force of all the New England states.

1.2.8 Labor Demand

In the 1980s, Maine reached new levels of economic prosperity, influenced, in part, by the growth of the real estate market and, in part, by a restructuring of the state's manufacturing sector. Industrial restructuring has been painful both in the state and in the region as legions of shoe, textile and durable goods manufacturers either left the state for less expensive labor and energy costs in the south, or went out of business altogether.

Maine's ability to sustain economic growth and thus create jobs in the 1990s may well be imperiled by demographic factors. The 18-24 age group whose members typically fill the newly created, entry level jobs is expected to experience an absolute decline of 14 percent through the year 2010. This loss will exacerbate tight labor market conditions that may emerge through the 1990s.

If the predictions of the Commission on Maine's Future are realized, that the economy has the potential to double over 1985 levels by the year 2010, employment gains associated with this level of growth could equal 40 percent. However, during the same period, labor force growth is estimated to be only about 20 percent, which will limit total possible growth.

A recent review of Maine's economy by the Maine State Planning Office offered a short-term outlook which included the following:

- A region-wide economic slowdown, begun in 1988, will affect Maine's economy until 1992.
- Employment growth, which averaged 4.3 percent between 1986 and 1988, is estimated to fall to less than half that rate between 1990 and 1992.
- Housing starts will average 8,000 per year, compared to the 10,000-11,000 starts in recent years.
- Consumer spending, which lagged in 1989, is expected to rebound in late 1990 to drive modest expansion in consumer sales.

The long-term outlook for the economy includes the following:

- Economic growth will occur at a more moderate pace than that of the 1980s.
- Employment growth will slow down.
- Employment structure will continue its shift to the service-producing industries, which are expected to grow to 84 percent of total employment by the year 2000.
- Total population will reach 1.3 million people by the year 2000, a 9 percent increase over 1988. It will be a significantly older population, with more people over age 40 than under.
- The number of households will continue to increase at a faster rate than the population.

1.2.9 Maine's Values

The telephone poll of 784 Maine residents conducted in 1987 by the Commission on Maine's Future asked 79 questions, most of which were belief questions. Respondents were asked to "agree/disagree" on a scale of 1 to 5. Highlights from the poll include:

- Concern about change and its threat to the Maine way of life is genuine; 4 out of 10 want it to stop.
- A majority in all parts of the state think Maine and its communities are better off now than they were ten years ago.
- A significant minority of believe Maine a tough place to make a living and tend to have a "backwater" image of the state.
- Mainers place high value on education.
- Mainers tend to see the main purpose of education as being preparation for a job, rather than stimulation of creativity and personal growth.
- A plurality think Maine's schools are "failing to prepare children for the future."
- Half of the people regularly attend a place of worship and nearly six in ten consider prayer important in their day-to-day decision-making.
- More than six in ten think society is not as morally strong as when they were growing up.
- A majority opposes censorship in community-supported libraries, and there is a general preference for living in places where there are people of different background and beliefs.
- Older, lower income, and longtime residents are skeptical about a powerful state bureaucracy.
- More than half believe that big corporations have too much influence over government; yet, a majority still believe they can affect government.
- Mainers prefer self-reliance in theory but in practice a majority believe government should assure such basics as housing and health care.
- Mainers are divided on whether there is a sense of loyalty anymore in the workplace.

- Four in ten people do not think workers care about the quality of their work as much as workers did in the past.

- Forty-five percent of residents consider labor unions necessary to protect the jobs and rights of workers.

Maine is a large and diverse state. Our analysis of its geography, social and political structure, and demographics have led us to choose two intervention sites within the state: Portland, the largest city in the state; and Franklin County (with Livermore Falls from northern Androscoggin County), an area of low population density whose economy is based on the lumber, shoe and tourism industries. These sites will serve as excellent models for intervention elsewhere in the state, and further, throughout the country. In addition to these two specific intervention sites, ASSIST will address the entire state.

1.3 Portland

Portland, Maine is the largest municipality in the state, with a population of 67,000. It is the hub of financial, social, health and human services delivery to surrounding areas. Portland is a harbor town located on a peninsula on the south coast of the state.

The city's natural harbor is the most active north of Boston. Its land mass is 27 square miles. Within the city limits there are distinct neighborhoods: twelve on the mainland and five representing the islands with the greatest year-round populations. Neighborhoods are demarcated not only geographically, but ethnically and socially as well. Portland has a public bus system that serves all areas of the city. The city is surrounded by twelve municipalities that along with Portland, comprise the Greater Portland Area, which has a combined population of greater than 200,000.

The Greater Portland Area is in Cumberland County, the most highly populated county in the state. Total county population is 250,000 (Table I.1, p. 17), indicating that the bulk of the population is centered around Portland itself and its neighboring towns. Although the ASSIST intervention site will include only the city of Portland, it is important to understand the relationship between this city and the twelve outlying communities. There are no significant geographic or other barriers that separate these communities from each other, save a few rivers. Citizens flow easily between communities to access needed services, partake in social and cultural events, enroll in educational programs, or obtain employment.

As was mentioned previously, county government in Maine is generally weak. Cumberland County government provides law enforcement services and courts and operates the Cumberland County Civic Center in downtown Portland.

Table I.1
Population Growth for Portland, Portland MSA, and Cumberland County

CITY/TOWN	1970	1980	EST. 1987	1980-87 PERCENT INCREASE	SQUARE MILES LAND AREA	POPULATION DENSITY PER SQ. MILE
Cape Elizabeth	7,873	7,838	8,833	12.7	15.7	563
Cumberland	4,096	5,284	6,360	20.4	25.7	247
Falmouth	6,291	6,853	7,695	12.3	24.8	310
Freeport	4,781	5,863	7,079	20.7	34.5	205
Gorham	7,839	10,101	11,679	15.6	51.5	227
Gray	2,939	4,344	5,709	31.4	46.3	123
North Yarmouth	1,383	1,919	2,415	25.8	21.3	113
Portland	65,116	61,572	66,337	7.7	22.4	2,961
Scarborough	7,845	11,347	13,876	22.3	48.5	2,165
South Portland	23,267	22,712	25,326	11.5	11.7	931
Westbrook	14,444	14,976	16,098	7.5	17.3	931
Windham	6,593	11,282	13,205	17.0	46.8	282
Yarmouth	4,854	6,585	7,910	20.1	13.7	557
TOTAL GREATER PORTLAND:	157,321	170,676	192,522	12.8	380.2	506
TOTAL PORTLAND HSA:*	174,403	189,888	220,737	16.2	602.3	366
TOTAL CUMBERLAND COUNTY:	192,528	215,789	248,115	15.0	875.2	283

* Redefined in 1983, adding four municipalities and dropping one. Under the new definition, 1980 MSA population would have been 193,831.

Source: Greater Portland Council of Governments

Table I.2
Household Change for Greater Portland Area

	HOUSEHOLDS 1970	HOUSEHOLDS 1980	% CHANGE 1970-1980	HHS[1] 1980	EST. HOUSEHOLDS 1987	EST. HOUSEHOLD SIZE[1] 1987
Cape Elizabeth	2,280	2,780	21.9	2.88	3,166	2.79
Cumberland	1,192	1,689	41.7	3.13	2,099	3.03
Falmouth	1,935	2,469	27.6	2.72	2,926	2.63
Freeport	1,493	2,121	42.1	2.69	2,712	2.61
Gorham	2,080	3,217	54.7	2.83	4,247	2.75
Gray	864	1,503	74.0	2.83	2,084	2.74
North Yarmouth	370	595	61.2	3.23	787	3.07
Portland	22,780	25,419	11.6	2.35	29,095	2.28
Scarborough	2,358	3,905	65.6	2.89	4,921	2.82
South Portland	6,881	8,153	18.5	2.68	9,741	2.60
Westbrook	4,524	5,475	21.0	2.73	6,052	2.66
Windham	1,871	3,578	91.2	2.97	4,650	2.84
Yarmouth	1,482	2,436	64.4	2.55	3,078	2.57
TOTAL	50,110	63,340	26.4	2.61	75,556	2.55

[1] Persons per household; group quarters population is separated out for 1980 but not for 1987. The comparable 1980 HHS (with group quarters population included) would have been 2.69.

Source: U.S. Census
Greater Portland Council of Governments

Table I.3
Social and Economic Characteristics of Portland, Portland MSA, and Cumberland County

	CITY OF PORTLAND	PORTLAND M.S.A.	CUMBERLAND COUNTY
FAMILIES BY INCOME			
1980 (Census)			
Under $10,000	26.6	19.7	20.3
$10 to $19,999	34.6	35.4	35.8
$20 to $34,999	29.4	34.1	32.8
$35 to $49,999	6.5	7.0	7.2
$50,000+	2.9	3.8	3.8
Median	$16,616	$18,548	$18,290
Average	$19,228	$21,150	$20,984
1987 (Est.)			
Under $10,000	14.8	11.2	11.7
$10 to $19,999	25.2	21.6	22.3
$20 to $34,999	32.2	35.4	34.9
$35 to $49,999	16.1	18.4	17.6
$50,000+	11.8	13.4	13.5
Median	$24,215	$26,748	$26,250
Average	$35,059	$37,791	$37,581
PER CAPITA INCOME			
1980	$6,416	$6,761	$6,695
1987	$11,746	$12,424	$12,309
EDUCATION OF ADULTS (1987-%)			
Population 25+	38,343	117,389	129,988
High School Only	36.8%	38.6%	38.3%
College 1-3 years	16.8%	18.1%	17.7%
College 4+ years	19.3%	18.7%	19.0%
OCCUPATIONS (1987-%)			
Managerial/Executive	9.7	10.2	10.1
Professional	15.2	13.5	13.8
Technical	3.0	3.0	3.0
Clerical	20.8	18.2	17.9
Sales	11.0	11.4	11.2
Total White Collar	59.7	56.3	56.1
Craftsmen	10.0	12.6	12.5
Operatives	9.2	12.8	12.6
Services	15.6	13.0	13.2
Laborers	4.6	4.0	4.0
Farm Workers	0.8	1.3	1.7
Total Blue Collar	40.3	43.7	43.9
WORKERS IN FAMILY (1980-%)			
Total No. Families (1987)	13,916	53,932	59,770
W/ no workers	14.7	12.3	12.3
W/ 1 worker	32.1	30.2	30.9
W/ 2 or more workers	53.0	57.5	56.7
Working Mothers	57.6	58.5	56.9
Non-working Mothers	42.3	41.5	43.0

Source: Urban Decision Systems, Inc.

Portland is rich in ethnic diversity. There are distinct communities where people of specific national origin reside including: Italian, Greek, Polish, German, and East Asian. The Refugee Resettlement Program based in Portland has relocated 1,500 refugees to the area. Approximately 1,000 refugees now reside in Portland. The largest ethnic group is comprised of Vietnamese, Laotian, and Cambodian people. Recently, increasing numbers have relocated from Ethiopia, Afghanistan, and the Eastern Bloc countries.

Portland's population is extremely varied in occupation, educational attainment, income, and place of residence. The population density per square mile is 2,961, compared to that of the Portland Standard Metropolitan Statistical Area of 366, of Cumberland County, 283, and of the state, 39. There are an estimated 30,000 households with an average size of 2.28 persons, compared to the area average of 2.55. The median age of Portland's residents is 30.9 years. The median income of families is $24,215, with a per capita income of $11,746. The educational preparation of residents who are 25 years or older is about half with high school education or less, and the remainder with either some college (16.8%) or four or more years of college (19.3%). The distribution of occupations is 56.1% white collar and 43.9% blue collar.

These statistics for Portland have been greatly influenced by the in-migration that has been occurring over the past decade. Nearly seventy-five percent of the in-migrants were under the age of 50 years. Educational attainment by the in-migrants is high, with 39% of the females and 51% of the males having sixteen or more years of school, which is more than twice the rate of the adult population at large.

The city is organized following the councilor-manager model. The council is composed of nine elected members. From within this group a mayor is elected. The city manager is a non-elected position and serves as the chief administrative officer for the organization. The property tax is the funding base for most municipal and school programs. Portland has responded well to its responsibility in serving its disadvantaged citizens.

Portland is one of only two cities in the entire state that supports local public health services through its Department of Health and Human Services. Portland is widely recognized as a compassionate and caring community. Its number of human services resources support this notion.

1.4 Franklin County Area

The northern Androscoggin County town of Livermore Falls with Franklin County comprise a distinct rural community area based on historically shared medical, social, and commercial services. The total population is 37,000. Population is concentrated in four towns; Farmington, Jay, Livermore Falls, and Wilton, averaging 6,000 each. These towns are situated along the major traffic artery, Route 4, which is the major commercial and shopping strip for the area. There are six small towns, with populations between one and two thousand (Chesterville, Kingfield, New Sharon, Phillips, Strong, and Rangeley). The remaining townships are either very small towns or unincorporated areas. Population density of 18 persons per square mile is less than half the Maine average of 39 (Table I.3, p. 19). Even the large towns have very low population densities outside of the central cores.

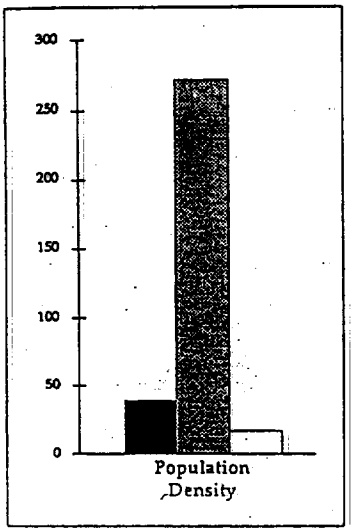
Once an agricultural area, the current economic base is lumber and wood products. A secondary industrial base oriented around shoe production still exists, though it has declined in the last decade. Tourism has emerged as the current second tier of the economic base. Ski resorts, lakeside condominium development, and a market for vacation homes have overshadowed the traditional small scale hunting, fishing, and lakeside camps. Mechanization of the lumbering industry has led to increases in the amount of wood produced, trucked and turned into paper and milled goods, although relatively smaller numbers of lumberers account for the output. Jobs outside of the papermills are low paying, as summarized in Table I.4 (p. 20).

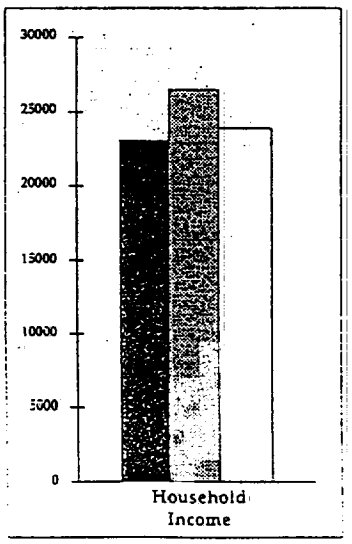
The area tends to be predominately rural with a lower than average income. Table I.5 (p. 21) displays the total number of households and income levels for the county, for three towns and for rural Franklin County, where income levels are dramatically low. Table I.6 (p. 21) summarizes the poverty indicators of AFDC and food stamp recipients, and highlights the towns with high concentrations of these indicators. Despite these facts, there remains a high degree of social stigma attached to receiving "welfare," especially in small towns where a tradition of self-sufficiency persists.

Rigid fiscal and social conservatism exists in local government. Town meetings and citizen selectmen frugally guard town budgets, which reflect core town roles of road maintenance, volunteer fire protection, waste disposal, and compliance with federal and state legislation. Social and health needs are seen as matters for the state or the few regional health and social service organizations which serve the area. Comprehensive town and regional planning, though recently mandated by the state, is as yet an idea whose time has not come. County government is even more limited in scope,

although in recent years some precedent for limited funding of regional health and service agencies has developed. Five school districts serve the area and form distinct subdivisions focusing on many community activities, the most spirited of which are debates about the school budgets.

Table I.3
Population Indicators for Maine, Cumberland County, and Franklin County, 1990





Maine

Population (1990)	1.2 million
Density	39 per square mile
Minorities	1.16%
Marriage rate	10.8 per thousand
Divorce rate	5.0 per thousand
Median household income	$23,079

Cumberland County

Population (1990)	237,950
Density	272 per square mile
Minorities	1.29%
Marriage rate	11.1 per thousand
Divorce rate	4.9 per thousand
Median household income	$26,589 - county $21,447 - Portland

Franklin County

Population (1990)	29,950
Density	18 per square mile
Minorities	.35%
Marriage rate	10.3 per thousand
Divorce rate	4.6 per thousand
Median household income	$23,960

Source: Maine Department of Human Services, Office of Vital Statistics

Table I.4
Jobs in Franklin County by Category and Industry Setting

◆ **Job Category**

Lowest Paying Jobs Employing High Number of Workers

1. food preparation
2. nurse aide (or orderly)
3. gardener/grounds keeper
4. cashier
5. kitchen help
6. sales clerk
7. short order cook

◆ **Industry Job Setting**

Less than $11,000 Annual Wage*

		# of Employees
1.	eating and drinking places	763
2.	hotels and other lodging places	330
3.	food stores	427
4.	special trade contractors	166
5.	personal services	57
6.	furniture and home furnishing stores	33
7.	apparel and accessory stores	59
8.	membership organizations	39
9.	general merchandise stores	205
10.	leather and leather products	1,295

Less than $15,000 Annual Wage*

		# of Employees
1.	health services	885
2.	social services	283
3.	wholesale trade - durable goods	114
4.	miscellaneous retail	129
5.	auto repair, services and garages	48
6.	banking	157
7.	rubber and miscellaneous plastic products	179
8.	lumber and wood products	1,154

(*All wage scales based on 1980 Bureau of Census figures.)

Source: Maine Department of Labor, Bureau of Employment Security, Division of Economic Analysis and Research

Table I.5
Total Number of Households and Income Levels for Franklin County

	Franklin County	Farmington (CDP)	Jay	Livermore Falls	Rural Franklin County
Total Households	9,420	1,122	1,690	1,316	8,298
< $5,000	1,344	188	163	244	1,156
5,000-7,499	949	134	126	163	815
7,500-9,999	1,058	128	114	92	930
10,000-14,999	1,866	238	225	210	1,628
15,000-19,999	1,409	142	291	169	1,267
20,000-34,999	2,237	237	610	348	2,000
35,000-49,999	396	38	127	72	358
50,000 or more	161	17	34	18	144
Female household (no husbands)		234	113	137	
Female households below poverty line		63	36	34	208

Source: Maine Department of Human Services, Office of Vital Statistics

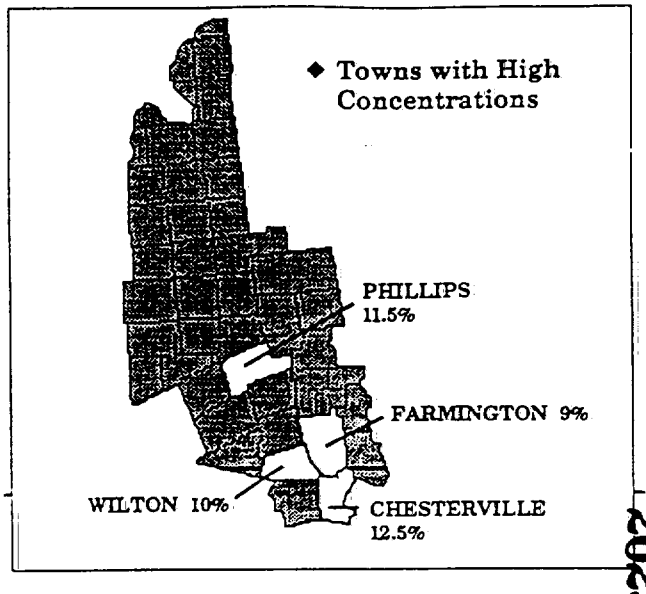
Table I.6
Poverty Indicators of AFDC and Food Stamp Recipients in Franklin County

◆ Average Households Receiving Benefits

	No.	%
Food Stamps	1075	8.2
AFDC	504	4.8

◆ Average Household Size

Food Stamps	2.28
AFDC	2.82



Source: Maine Department of Human Services, Office of Vital Statistics

Aside from a limited mini-bus transportation service for senior citizens, the absence of public transportation combines with geographic isolation and limited social and cultural services to produce a social isolation for the poor that is profound. Success in overcoming these barriers offers a challenge for intervention efforts and promises to have wide applicability in other rural areas of both the state and the nation.

II. STRUCTURE OF CHANNELS FOR SMOKING PREVENTION AND CONTROL

II. STRUCTURE OF CHANNELS FOR SMOKING PREVENTION AND CONTROL

2.1 Health Care Delivery System

The organization of Maine's health care delivery system is heavily influenced by the state's rural nature. Reflecting patterns in the general population, the most intensive distribution of medical personnel and facilities is found in the southern coastal region. In most regions, the system faces challenges of providing services in large areas with low population density (areas which cannot support large facilities with the full range of technologies, and which often have difficulty in recruiting physicians and other health care professionals). Some of the smaller hospitals have closed in the face of the last decade of fiscal pressures.

In these same broad terms, Maine's health care delivery system is also shaped by the absence of a substructure of county and local public health departments and by the limited number of institutions providing medical and public health education. There is an osteopathic school of medicine (the University of New England College of Osteopathic Medicine), as well as 14 programs offering professional nursing degrees; and no schools of public health in the state. Six family practice residency training programs have been established in the past two decades (Maine State Health Coordinating Council 1985). One branch of the university system (Farmington) offers an undergraduate degree in community health education.

Provision of many of the services and training has been built upon special contracts and collaborations. Thus, while certain expected statewide health service structures may be missing or decentralized, the delivery of health services of varied sorts in Maine has been built upon and, in turn, solidified traditions and networks of active cooperation and coalitions.

2.1.1 Maine

2.1.1.1 Health Care Facilities

There are currently 41 community acute care hospitals, in addition to a rehabilitation hospital, a private psychiatric hospital, a Veterans Administration hospital, and one U.S. Air Force Hospital. Two state mental health institutes provide care for patients with severe mental illness; another state institute serves the mentally retarded. Eastern Maine Medical Center, in Bangor, and Maine Medical Center, in Portland, are tertiary care facilities. Over 20,000 full-time equivalent employees work in Maine's hospitals (Maine Department of Human Services 1990a).

A survey of 39 hospitals in the state found that 31 offered smoking cessation programs, in some cases through outside consultants (American Lung Association of Maine 1990).

For many Maine citizens, and particularly for those in less populated areas, community health centers are the focus of the most accessible health services. Maine has 24 community health centers, including three Indian Health Centers. The majority of the 24 health centers are affiliated with either the Kennebec Valley Regional Health Agency (KVRHA), or the Rural Health Centers of Maine (RHCM). Health promotion/education and substance abuse services are already included in the centers' services (Maine Department of Human Services 1990a).

Twenty-three health centers are represented (either directly or as members of KVRHA and RHCM) by the Maine Ambulatory Care Coalition. In 1988, there were a total of 56,789 medical users of the 23 centers (range for individual centers: 280 - 4,427), and 3,281 dental users (range for individual centers: 0 - 1,851). The centers employ 286 people. The total population of the catchment areas served by these centers is 173,075. Smoking cessation services are provided at approximately half of the centers; substance abuse counseling is available at all but one (Maine Ambulatory Care Coalition 1989).

In total, the ambulatory care and rural health centers serve approximately half of Maine's towns and cities (Maine State Health Coordinating Council 1985).

Approximately 19,000 people received long term care in 1988 in Maine, in both intermediate care facilities (ICFs) and skilled nursing facilities (SNFs) (Maine Department of Human Services 1990a).

2.1.1.2 Public Health System

As a state composed primarily of small towns, locally-based health departments are uncommon in Maine. Only the cities of Portland and Bangor have health departments. Mid-sized cities and towns may have a paid Health Officer who delivers some public health programs. While towns are required to appoint a Health Officer, the individual may receive little or no pay, and usually has limited, if any, training in public health. Public health services in Maine are funded primarily by the state or federal government, with no uniform statewide system for the delivery of these services on the local level. Most health services are contracted by the state to community-based agencies. The Maine Public Health Association is active in the state; it has recently commissioned a study of public health resources and needs in Maine based largely on the Institute of Medicine report, "The Future of Public Health."

The Bureau of Health is organized within the Department of Human Services. Its divisions include Health Promotion and Education, Maternal and Child Health, Disease Control, Health Engineering, Public Health Nursing, and Public Health Laboratory. There is also an Office of Dental Health, which, like many of the divisions, provides statewide and community-based programs. With the exception of public health nurses and health engineers, there are no Bureau personnel in regional offices. The public health nurses make home visits and provide care through clinics; maternal and child health is a major focus of their programs. A thorough description of the Maine Bureau of Health is provided in Section VII.

Public health programs are under the jurisdiction of other state agencies also. For instance, school-based health education is the responsibility of the Department of Education. A history of collaboration between state agencies around public health issues has been established, however. For instance, the Departments of Human Services, Education, and Mental Health and Mental Retardation work together on substance abuse prevention programs. The Departments of Human Services and Mental Health and Mental Retardation have also collaborated in the provision of services to special populations such as the elderly, and for special need areas such as alcohol and drug abuse treatment services.

The Special Supplemental Food Program for Women, Infants and Children (WIC) is an example of a program contracted out by the state, in this case to 5 health agencies and 6 community action programs. Together these 11 programs operate from over 100 clinic sites. WIC serves women, infants and children up to age 5 who meet certain income guidelines. The primary services are nutritional, including food stamps and counseling. The program is designed to address nutritionally related gestational and early childhood disorders within a high risk population. Thus, while primary care medical services are not offered, program aims are health-related, and health referrals are made outside of the program where needed. Forty-eight percent of the pregnant women in Maine's WIC program smoke cigarettes. The average number of clients seen per month is currently in excess of 20,000. Typically, clients are seen every other month (Maine Department of Human Services 1989).

2.1.1.3 Publicly Administered Health Insurance

As of July 1, 1988, 7.6% of the population (91,422 individuals) were eligible for coverage by Medicaid. Approximately 28% of Medicaid expenditures were for hospital care, both inpatient and outpatient; approximately 45% of the program expenditures went for nursing home care. Also as of July 1, 1988, a total of 175,863 persons were covered by Part A of Medicare, 172,942 by Part B.

The Maine Health Program, which will go into effect Fall 1990, will provide health coverage for 25,000 uninsured Maine citizens whose families are at or below 95% of the National Poverty level. This is a publicly administered health insurance program providing comprehensive benefits. Over 100,000 Maine citizens will remain uninsured.

2.1.1.4 Health Maintenance Organizations (HMO)

Very few Maine citizens are covered by health maintenance organizations. A total of approximately 30,000 individuals are enrolled in the three HMOs in Maine. These programs, all of which operate within an IPA model, are available only through employer group coverage programs.

2.1.1.5 Other Programs

A range of other programs with more specialized medical and public health aims make up an important stratum of the health care system and provide other opportunities for access to both providers and their clients. The Maine Family Planning Association (MFPA) is one example. The purpose of MFPA is to assure that comprehensive, coordinated, cost efficient, high quality family planning services be available to the people of Maine. MFPA reaches 33,000 clients per year clinically; and 20,000 parents professionally and others educationally. Most of the clients seen are women in need, 150% of poverty. There are 40 clinics statewide offering clinical services, counseling, educational services, one-on-one interventions, group presentations, and trainings.

Screening programs, such as the prenatal screening program for open neural tube defects administered by the Foundation for Blood Research, can reach large numbers of providers and individuals. For example, approximately two-thirds of all pregnant women in Maine participate through their physician's practices in this prenatal screening program. This program has already been used as a trial vehicle for the delivery of a smoking cessation intervention to the pregnant women who smoke. This intervention is described in more detail in Section IV.

2.1.1.6 Organization of Health Care Providers

Table II.A.4.a (in the Appendix) lists the number of health care providers by specialty and location. This table includes both M.D.'s and D.O.'s (osteopathic physicians). Approximately 10% of the state's physicians are D.O.'s. In 1986, the statewide primary care physician to population ratio was 1:1,414. This ratio ranges from a high of 1:1,051 in Cumberland County to 1:2,317 in Waldo County (Maine Department of Human Services 1990a and State of Maine Health Policy Advisory Council 1989). Twenty-five primary care analysis areas are federally designated as primary care health manpower shortage areas (Watkins and Allen 1990).

Eighty-nine percent of licensed dentists belong to the Maine Dental Association. In 1986, the statewide dentist to population ratio was 1:2,515. This ratio ranges from a high of 1:1,143 in Cumberland County to 1:4,303 in Waldo County (Maine Department of Human Services 1990a). Eighty percent have solo private practices. Of the approximately 700 licensed practicing dental hygienists, the majority work in private dental practices. Ten percent belong to the Maine Dental Hygienists Association.

Table II.A.4.b (in the Appendix) lists providers of continuing professional education by specialty and location. The organizations providing these programs span a wide range of agencies and institutions throughout the state. Recently formed consortia, such as the Bingham Consortium for Health Research, the Maine Consortium for Health Professional Education, and the Katahdin Area Health Education Center are actively engaged in addressing the educational and research needs of health professionals (Watkins and Allen 1990).

2.1.1.7 Health Care-Related Unions

No centralized source of information on the distribution of health care-related unions and their memberships exists. With the exception of the Maine State Nurses Association (MSNA), much of the union organization of health care personnel is piecemeal, with members of the same professional group or job category variously belonging to unions based at their institutions or, across state, to one of several unions.

The MSNA is the primary union for nurses in the private sector, serving as both a professional organization and a union. Of the approximately 1,100 nurses who are members of MSNA, 62% belong to bargaining units represented by the Association. The primary union representing nurses in the public sector (e.g., those working in public hospitals and other institutions) is the Maine State Employees Union. The Maine State Employees Association (MSEA). The MSEA also represents all other health personnel employed by the state. In addition, two small bargaining units of nurses, one hospital-based, and one in a nursing home, are represented through the American Federation of Teachers (AFT).

Health-related personnel are also organized through the University of Maine System Professional and Staff Association (UMSPSA).

While not unions, a variety of provider organizations are based in the state. These include the Maine Hospital Association, the Maine Medical Association, the Maine Osteopathic Association, the Maine Health Care Association, and Home Health Care of Maine.

2.1.2 Portland

As the largest urban area in Maine, Portland has a number of fine medical facilities. Maine Medical Center is one of two tertiary care hospitals in the state. It has 600 inpatient beds, including a psychiatric unit. Maine Medical Center offers a wide array of outpatient clinics offering both general and specialized medical care. Mercy Hospital, the community hospital, has 200 inpatient beds that include an alcohol institute and a specialized respiratory floor. The catchment area for this institution is limited to the Greater Portland Area, in contrast to that of Maine Medical Center which serves the entire State of Maine and sections of southwestern New Hampshire. The Osteopathic Hospital provides osteopathic inpatient medical care to citizens of southern Maine. It serves as the teaching hospital of the University of New England College of Osteopathic Medicine. New England Rehabilitation Hospital has 76 beds for acute and skilled rehabilitation services.

Portland has four nursing homes. They are:

City of Portland Barron Center - 165 beds
Jewish Home for the Aged - 88 beds
St. Joseph's Manor - 200 beds
Woodfords Nursing Center - 154 beds.

Ambulatory care is available through the many private medical practices or centers. The medical centers are:

- Casco Bay Medical Center - The Center serves residents of Peak's Island.
- Maine Family Practice Unit - Family Practice residents receive training at the unit.
- Maine Medical Center Outpatient Clinics - Low-income clients from the all of Maine and Southern New Hampshire are served by the clinic.
- Martin's Point Health Care - The major client base is from the Department of Defense.
- Portland Public Health Division - There are four health stations located strategically throughout the city. Each health station is located in census tracts with the lowest income population group including the publicly operated housing project.
- Southern Coastal Family Planning - Reproductive health care is moderate to low income clients.
- Walk-in Clinic - There is currently one in Portland.

The greatest single source of health care services is fee-for-service private practitioners. The following list enumerates by specialty medical providers practicing in Portland:

Allopathic Physicians	Number	Osteopathic Physicians	Number
Allergy	8	Cardiology	3
Cardiology	20	Family Practice	6
Dermatology	8	Gastroenterology	1
Endocrinology	6	Internal Medicine	9
Family Practice	6	Manipulative Therapy	3
Hematology	5	Neurology	2
Internal Medicine	17	Obstetrics & Gynecology	2
Nephrology	6	Occupational Medicine	2
Neurology	7	Oncology	2
Obstetrics & Gynecology	21	Orthopedics	4
Occupational Medicine	2	Otorhinolaryngology	3
Oncology	12	Pulmonary Disease	2
Ophthalmology	9	General Surgery	8
Orthopedics	13	Special Surgery	7
Otorhinolaryngology	9		
Pediatrics	17		
Proctology	1		
Pulmonary Disease	13		
Rheumatology	5		
General Surgery	13		
Specialty Surgery	39		

Home health and private duty nursing services for Portland residents are provided by:

- Community Health Services
- First Allied Home Health
- Medical Personnel Pool
- Quality Care

Portland has several schools providing training in the health occupations. They are:

- Maine Medical Center - Surgical Technician School
- Mercy Hospital - School of X-Ray Technology and School for Certified Registered Nurse Anesthetists
- University of Southern Maine - School of Nursing: B.S.N. and M.S.N.
- Westbrook College School of Nursing: A.D.N. and B.S.N.

Health care providers are organized through their professional organizations and worksites. Continuing education is available through these avenues:

- Cumberland County Medical Society - allopathic physicians
- Maine State Nurse's Association District #4

- Sigma Theta Tau - nursing honorary
- Greater Portland Dental Society - monthly meetings
- Mercy Hospital Medical Staff - monthly meetings
- Maine Medical Center Medical Staff - monthly meetings
- Osteopathic Hospital Staff - monthly meetings

Health care unions do not play a big role in the work plan of the organizations discussed. Only two employee groups have union representation. They are:

- Community Health Services - 40 nurse members.
- City of Portland Health Workers - 200 represented through A.F.S.C.M.E. (American Federation of State, Community, and Municipal Employees)

2.1.3 Franklin County Area

Traditionally, fee-for-service private practitioners predominated the area's health care delivery system. In recent years a series of community health centers offering a federally subsidized sliding scale service fee, and employing salaried physicians and extenders has grown to four sites. The sponsoring organization is the Kennebec Valley Regional Health Association (KVRHA), based in a neighboring county, and operating in four counties. A statewide Blue Cross and Blue Shield HMO is the only HMO, and currently has a 17% market share. All local physicians accept Medicaid. The following medical practices by geography and specialty distribution represent the 39 physicians and 11 mid-level practitioners [either physician assistants (PAs) or nurse practitioners (NPs)]:

Primary Care

Farmington	
4 general internists, 1 PA	private
2 pediatricians	private
2 family practitioners	private
2 family practitioners, 1 PA	KVRHA
2 OB-GYN	private
1 family practitioner	college physician
Wilton	
1 general surgeon with primary care practice	private
1 OB-GYN, 1 NP	private
Livermore Falls	
2 family practitioners, 1 internist, 1 PA	KVRHA

Strong	
1 family practitioner, 1 PA	KVRHA
Kingfield	
1 family practitioner, 1 PA	KVRHA
Phillips	
1 family practitioner	private
Rangeley	
1 family practitioner	private

Specialty Care

Farmington	
2 general surgeons	private
3 orthopedic surgeons	private
1 otorhinolaryngologist	private
1 urologist	private
1 ophthamologist	private
3 anesthesiologists	private
2 emergency physicians, 4 PA's	salaried hospital
1 radiologist	private
1 pathologist	private
1 psychiatrist	part time private
1 PA	occupational medicine Franklin Memorial Hospital

Primary care access in the Route 4 corridor is very limited at the present time because of overburdened practices. Staff turnover at KVRHA's Farmington and Kingfield sites has threatened access further. The hospital and KVRHA are jointly recruiting for additional family physicians.

Franklin Memorial Hospital (FMH), a 70 bed community hospital in Farmington, is the central health care institution in the area and the only provider of continuing professional education. There is no health care workers union. All physicians in the area are members of the medical staff, which is the focus for all organized physician activity. Local dentists do not practice at the hospital on a regular basis and meet only sporadically for educational activities. A county medical society exists on paper only and represents half of the medical community that also belongs to the state medical society. Duplication of meetings and personnel and lack of a focus for activity are the reasons for the medical society's inactivity.

The average age of the medical staff is 45. A history of innovation in public health organization existed in the medical community in the 1970s. One example was Rural Health Associates (RHA), a group practice and rural HMO with direct involvement in a variety of health and prevention programs. It succumbed to financial pressures in 1981, taking with it a focus for leadership in medical and social service innovation and coordination in the area which was never restored. Nevertheless, significant interest remains in local public health matters among medical staff members, and among the new administration of the hospital, whose CEO has a nursing background.

One program with direct relevance to Project ASSIST is the 12 year-old **Franklin Blood Pressure/Cholesterol Program (FBPCP)**, headed by a local internist. This program offers screening, counselling, referral, and follow-up for hypertension and cholesterol problems. It is offered on a regular basis at a nominal cost to individuals at major worksites, schools, and community locations throughout the hospital service area. The program has evolved in the last year into a more comprehensive cardiovascular disease risk reduction program. There is now a focus on smoking prevention and cessation, heart-healthy food preparation in schools, restaurants and other institutions, and increased opportunities for wintertime adult physical exercise. Ongoing smoking cessation classes and a regional dietary coalition were achievements of the program in the past year. At the same time, it continues to offer (1) outreach screening for all medically recognized cardiovascular risk factors, (2) education of both the medical and general communities in risk education, and (3) tracking through computerized follow-up for all at-risk individuals. Identification of high tobacco use rates in high school screenings led directly to the CHEP described below.

The **Cooperative Health Education Project (CHEP)** now a year old, has successfully integrated physicians and nurses into school health teams for the purpose of enhanced school prevention efforts in two of the five school districts served by FMH. Over forty classroom teachers were paired with medical professionals (including 25 members of the hospital medical staff) to plan and implement curriculum in tobacco use prevention in one school district and in AIDS related education in another. Planning for the effort grew out of a collaboration between the hospital, medical staff members, the American Lung Association, the local state university, and one of the school districts. The project is coordinated by a physician and the director of the hospital education department. The success of the program (as measured by student, teacher, and medical participant evaluations) has led to a goal of further involvement in the comprehensive health education curriculum of the schools, while maintaining the team concept, and expanding the program to other school districts in the community. Expansion of the project committee to including leaders of clergy and local industry occurred in the spring of 1989. The project is included in the hospital work plan for the next year in expanded community prevention services.

Nursing activity in Farmington/Livermore Falls is centered in five areas. School nursing will be described under the school section. Hospital nursing is focused around the departments of nursing and education (1.5 nurse educational specialists) at the hospital. Nurses from both areas are actively involved in the CHEP project. Nursing homes employ significant numbers of nurses, representing another potential source of medical expertise that could be mobilized for community efforts. Public health nursing includes two state public health nurses for the entire area who do home visits and conduct some immunization clinics. Androscoggin Home Health Services (AHHS) is a regional home health organization offering a full range of home services. It has recently been funded to also do high risk pediatric and family home nursing as well. Industrial nursing includes on site nurses at three of the larger employers. The only nursing associations are at the state level.

There is no public health department at the local or county level. Each town appoints a nominal health officer, usually a local physician or nurse, who mainly functions when requested because of an identified acute health problem.

2.2 Worksites and Economic Picture

2.2.1 Maine

2.2.1.1 Geographic Distribution of Working Populations

The annual average civilian labor force numbered 598,000 in 1988, while 22,000 people were unemployed for an annual rate of 3.8 percent. Monthly unemployment rates varied from a low of 2.4 percent in August to a high of 4.8 percent in February. Approximately 10 percent of the Maine civilian labor workforce is employed in agriculture. Table II.1 (p.35), gives a breakdown of the civilian labor force and unemployment rate by county.

Table II.1
Civilian Labor Force for Maine Counties, 1988

County	Annual Average Civilian Labor Force	Annual Unemployment Rate
Androscoggin	48,290	4.3
Aroostook	37,780	6.7
Cumberland	136,810	2.0
Franklin	12,530	4.5
Hancock	23,990	4.5
Kennebec	56,670	3.4
Knox	16,260	3.6
Lincoln	16,870	3.0
Oxford	22,460	4.6
Penobscot	66,840	3.8
Piscataquis	8,470	4.6
Sagadahoc	14,990	2.5
Somerset	21,640	6.0
Waldo	12,780	7.6
Washington	14,470	8.7
York	87,170	2.4

Source: Maine Department of Labor, 1988

A breakdown of non-farm wage and salary employment by major industry for 1988 is shown below in Table II.2.

Table II.2
Non-Farm Wage and Salary Employment
by Major Industry, 1988

Major Industry	Percent
Services and Mining	22.0
Retail Trade	20.2
Government	17.4
Manufacturing, nondurable	11.0
Manufacturing, durable	9.5
Construction	6.3
Wholesale Trade	4.8
Finance, Insurance and Real Estate	4.8
Transportation and Public Utilities	4.0

Source: Maine Department of Labor, 1988

Maine's top 50 employers employ a total of 93,000 people (which does not include banks, federal, military, state, municipal, and university employees). The next table (Table II.3) shows the distribution of these employers by county. Of note is the absence of a major employer in Knox, Waldo, and Washington Counties.

Table II.3
Distribution of Maine's Major Employers by County

County	No. of Major Employers
Androscoggin	8
Aroostook	2
Cumberland	14
Franklin	3
Hancock	1
Kennebec	9
Knox	0
Lincoln	1
Oxford	1
Penobscot	10
Piscataquis	1
Sagadahoc	2
Somerset	4
Waldo	0
Washington	0
York	6

Source: Maine Department of Labor, 1988

The following are required tables and can be found in the Appendix: Table II.B.5.a.1 - Worksite Distribution by SIC Codes and County, Table II.B.5.a.2 - Worksite Distribution by SIC Codes and Number of Employees, and Table II.B.5.b - Labor Force and Employment Status.

An important feature of the labor picture in Maine is the high number of businesses that employ less than 20 employees. For example, according to statistics compiled for March 1988 by the Maine Department of Labor, of the 35,227 employers in business at that time, 87 percent of them employed fewer than 20 people. In fact, 20,139 employers, or 57 percent, employed from 0-4 people. This fact is important when considering resource allocation to worksite smoking cessation programs; a majority of Maine workers are employed at work sites of 4 or fewer people.

2.2.1.2 Networks Linking Businesses

There are 66 local Chambers of Commerce in Maine. Each serve the state in such geographically diverse areas as York in the south, Greenville to the west, and Presque Isle in the north.

In addition, there are 90 professional and trade associations, ranging from the Christmas Tree Association and Maple Producers to the Maine Association of Engineers.

As noted previously, small business is dominant in Maine. In the early 1980s, 60 percent of state businesses employed one to three persons. With such a large number of small businesses, there are few opportunities to link them together beyond local Rotary Clubs or Chambers of Commerce.

The Office of Business Development, contained in the Department of Economic and Community Development, provides assistance to businesses through the:

1. Small Business Assistance network - offers counseling services to small businesses

2. Maine Products Marketing Program - offers producers assistance in marketing industrial and consumer products through trade shows and catalogs

3. Supplier Network Program - links producers and suppliers with subcontractors and businesses both in-state and out-of-state

2.2.1.3 Influence and Structure of Unions

There are 4 principal unions in Maine. The Maine AFL-CIO is the umbrella for a number of trade unions including paper workers. It is affiliated with the national AFL-CIO. Fifteen to seventeen percent of Maine workers belong to labor unions.

The primary independent unions include the Maine State Employees Association, which represent state workers; the Maine Teachers Associations, which is affiliated with the national union; and the Teamsters Union. Together, these unions represent a little less than 20 percent of Maine workers.

Organized labor has been and still is very active in the Maine Legislature. They lobby for workers compensation issues and more stringent workplace safety regulations.

The Maine Labor Group on Health (MLGH) comprised of local unions, health and safety professionals, health care providers, labor lawyers, and community activists, is a private, nonprofit corporation. The

Group's objectives are to educate working people about health and safety in the workplace, and to function as a statewide advocate for working people within the health care system.

MLGH provides a number of services to its constituents including:

- asbestos abatement training
- health and safety training courses for handling hazardous materials
- courses in lead paint abatement
- training programs for industrial painters, cosmetologists, agricultural workers
- research projects developed around particular occupational health and safety issues

2.2.2 Portland

Portland benefited greatly from the economic resurgence experienced throughout northern New England in the 1980s. However, it is now feeling the effects of the economic in the region. It is predicted that this economic situation will not improve for three to five years. The downtown area experienced significant growth in the commercial real estate market during the economic upswing, which is evidenced by the dramatic increase in the number of tall buildings in the city's skyline. However, as the economy wanes, it appears that the very visible financial and real estate development industries will be most greatly affected. The city leaders are striving to stop the spread of this impact into other areas of industry.

Despite the ups and downs of the economy over the course of Portland's history, there has always been a strong commitment to maintain the infrastructure. Portland, therefore, has been and remains attractive as a home for large employers.

The ingenuity, productivity, and skills of Maine workers are legendary. They continue to be one of Portland's strongest assets. This along with the previously mentioned talent and education of the in-migrants make establishing worksites in this city very popular. As a result, unemployment rates have stayed just below the 4.0% level for a number of years.

There are over seventy companies in Portland with 100 or more employees. There are 32,742 workers employed in companies with 50 or more employees.

Commercial/industrial activity is concentrated in three areas. Marine-related and other industries are located on the waterfront, which also boasts the restored Old Port area of shops, businesses, and restaurants. Industrial parks are located on both the northern and western boundaries of the city.

Portland is fortunate to have three service clubs that bring the business community closer together. They are the Rotary, Lions and Kiwanis. Additionally, the city has a very strong and highly visible United Way that is a model for linking the private, public, and nonprofit sectors together. The United Way, Inc. of Portland has two programs that are national models. The first is called the Referral Agent Program. It is designed to address the needs of workers (and their families) in both union and nonunion settings. In nonunion settings, an employee is trained to be a referral agent; in union settings an employee is designated as union counselor. Training is geared to link employees with information regarding access to health and human services.

The second program is "At Work." It is designed to help employers serve a variety of employee needs - social, educational, and health related. United Way At Work is the response to these changing dynamics in the workplace. The At Work Program differs by employer and work site. However, no matter what the design, they all meet employee needs by:

- promoting employee health.
- providing access to health and human care services.
- providing opportunities to give time and talent.
- provide an opportunity to contribute dollars to their communities.

There are four components to the At Work Program:

1. Volunteer Works - develop volunteer resources through corporate involvement.

2. Campaign Works - raise funds from employees to support health and human care services.

3. Info Works - (formerly called the Referral Agency Program) - increases employee access to health and human care organizations.

4. Health Works - to promote and facilitate, through the Wellness Council of Southern Maine, the implementation and/or enhancement of workplace wellness programs.

The Wellness Council of Southern Maine is sponsored by the United Way At Work Program. The model for this program comes from Wellness Councils of America, a national umbrella organization dedicated to promoting more healthful lifestyles for all Americans. The local Wellness Council is a group of employers, including large and small business, nonprofit organizations, and educational institutions, who have joined together voluntarily to promote programs at the worksites to help their employees pursue more healthful lifestyles.

Portland also has a strong Chamber of Commerce that works very closely with all sectors of the business community. The Chamber schedules frequent opportunities to bring businesses together. Also there are several geographically delineated business organizations that strengthen the business environment. They include the Intown Portland Exchange, Uptown and Company, and the Waterfront Alliance.

Labor union presence is viewed positively in Portland. Thirty-seven labor organizations have state headquarters in the city. Portland is also home to four labor councils including the Greater Portland Federated Labor Council, Maine State American Postal Workers Union, Maine State Association of Letter Carriers, and Maine State Building and Construction Trades Council. Table II.4 shows the number of workers by type of industry.

Table II.4
Types of Industry and Number of Workers in Portland, 1985

Types of Industry	Number of Workers
DURABLE GOODS	7,330
Lumber	497
Stone, Clay & Glass	128
Fabricated Metals	825
Primary Metals	33
Nonelectric Machinery	2,109
Electric & Electronic Equipment	3,454
Transportation Equipment	75
NONDURABLE GOODS	7,861
Food	1,851
Apparel	503
Printing	1,385
Chemicals	N/A
Rubber and Plastics	N/A
Miscellaneous	88
Paper	N/A
TOTAL	15,191

N/A = Not Available, state data not disclosed
Source: Census of Maine Manufacturers, 1985

2.2.3 Franklin County Area

The mid 1980s saw the loss of many shoe-related jobs. Although the threat of further layoffs in this sector is not gone, the current economic climate appears stable.

Unionization in the area is limited to teachers and state employees. The shoe, leather, lumbering and paper, service (including health care) and tourist industries which predominate are nonunion. Twelve-hundred employees of the International Paper Company, the largest employer in the area, were the stronghold of union activity in the area before a large number were displaced during an unsuccessful strike in 1987. Only 250 of these strikers currently work at the mill.

A recent survey of all worksites in the area was conducted under a research grant by the Franklin County Children's Task Force (FCCTF), the local child abuse and neglect prevention council. It revealed very limited resources for employee assistance, with a few exceptions, such as a smoking cessation program offered on company time at Forster Manufacturing (the second largest employer in the area). Employers identified stress reduction and financial management as areas of high concern for their employees. Table I.4 (Section 1.4, p. 20) lists predominant job categories by number.

Business networks include the Western Mountains Chamber of Commerce, the Rotary, and the United Way. All three are area wide. In addition, a regional philanthropic development group, the Western Mountains Alliance, includes CEO's of all of the major industries in the area. Its target population extends across an area of five counties. The board has recently voted to concentrate in the areas of comprehensive regional planning and rural leadership skills training. Trade and professional organizations exist only at the state level.

2.3 Educational System

2.3.1 Maine

2.3.1.1 Schools

Youths represent the population of chief opportunity for smoking prevention programs. Schools, in turn, represent a very effective channel for both prevention and cessation programs, by virtue of being unique environments supportive of formal and informal learning. Formal classroom learning and informal learning through observation of teacher and administrator role models can greatly influence students of all ages. The educational environment supports learning by teachers and other school employees as well as by students. There are a variety of school settings in Maine (Table II.5, p.42).

Table II.5
Number and Type of Schools in Maine

School Type	Number: Public	Private
Secondary (High) Schools	109	22
Elementary Schools	600	61
Combined Elementary and Secondary*	40	17
Vocational Centers	28	
Technical Colleges	6	
State University Branches	8	
Colleges**	16	
Community Junior Colleges	5	
Adult Education Programs at Local Schools	159	

*any combination with both elementary and secondary grades
**public/private breakdown not available

Source: Maine Department of Educational and Cultural Services, 1989

A detailed breakdown of schools is shown in Table II.C.3 (in the Appendix). As was described in the introduction, Maine is a large state with low population density. These physical and demographic characteristics have led to the organization of schools by cities and towns with individual supervision, school administrative districts (SADs), units within school unions, community school districts (CSDs), units under district superintendents, and unorganized territories.

The simplest way to look at this information in is by noting that each table is mutually exclusive. Thus, any individual school appears only once in all of the tables. Confusion arises in that, the schools within any town or city may be a part of a union, part of a school administrative district, and so on. Children from one family, therefore, may be in schools supervised by different administrative bodies. Perhaps the most important message to be gleaned from analysis of Maine's somewhat quirky system of school administration is that any effort to reach students in schools must be implemented statewide to ensure that no school is excluded.

Student attendance broken down by school grade level and sex appears in Table II.6 below.

Table II.6
Student Attendance by Grade Level and Sex

Grade Level	Male	Female	Total
Total Students	106,699	100,272	206,971
Secondary School*	30,047	28,793	58,840
Elementary School	76,652	71,479	148,131
Post Secondary and Vocational Schools	9,269	15,350	27,167

*Secondary School is grades 9-12, Elementary, K-8.

Source: Maine Department of Educational and Cultural Services, 1989

Within schools, the number of students from minority groups (Table II.7) is slightly higher then their representation in the general population. This is likely due to the slightly greater number of black and oriental students than would be expected from the overall population statistics. This also may indicate growth in these populations, which will be considered in our Phase I analysis.

Table II.7
Minority Students by Sex

Minority Students Grades K-12	Male	Female	Total(%)
Blacks	542	441	983(0.5%)
Hispanics	259	230	489(0.2%)
Native American	415	426	841(0.4%)
Oriental	569	489	1,058(0.5%)
Other	211	207	418(0.2%)
Total	1,996	1,793	3,789(1.83%)

Source: Maine Department of Educational and Cultural Services, 1989

Maine's private elementary and secondary schools fall into two categories: approved (62%) and unapproved (38%). Approved schools meet state curriculum requirements and can receive publicly funded students. Unapproved schools are recognized by the state only for compulsory attendance requirements.

2.3.1.2 School Employees

There are 13,874 teachers at Maine elementary (9,036) and secondary (4,838) schools. Other school-related employees include school nurses (330), school food service workers (1,888), custodians and bus drivers (2,665), guidance counselors (550), and adult education directors (159).

2.3.1.3 Professional and Other Educational Organizations

Maine is fortunate to have numerous professional and other groups organized around its schools. They are:

Maine Teachers Association
Maine School Management Association
Maine School Nurses Association
Maine Guidance Counselors Association
Maine School Food Service Association
Maine School Boards Association
Maine Elementary Schools Principals Association
Maine Secondary Schools Principals Association
Maine Medical Association, Committee on School Health
Maine Association of Independent Schools
Maine Association of Christian Schools
Roman Catholic Diocese of Portland
Student Council Association
Parent Teacher Association
Maine Association for Health, Physical Education, Recreation and Dance
Maine School Health Education Coalition

2.3.1.4 Adult Education

Maine has a large and vital system of adult education. In the 1988-89 academic year, 12,822 (57% were women, and 43% men) were enrolled in adult education programs in the state. Of these, 3,800 graduated from general equivalency and diploma programs. The number graduating from these programs has been relatively stable since the 1970s.

2.3.1.5 Dropouts

The Department of Education Office of Truancy, Dropout, and Alternative Education calculates annual high school dropout rates for the state, counties, and individual schools. This dropout rate is a percentage of the fall enrollment for all students in grades 9-12. The dropout rate has remained relatively constant through the 1980's, between 3% and 5%. Most dropouts occur in the 10th and 11th grades.

More males than females drop out, with a difference of about 1.5%. An interesting leap in both the dropout and truancy rates occurred in 1987-88, however, rates dropped back to the annual average in 1988-89.

Portland has the highest dropout rate in the state for public secondary schools, 10.77% in 1988-89.

The state graduation rate for the class of 1989 was 79.3%. The loss rate of 19.7% represents dropouts, transfers, deaths, and other reasons for leaving school.

2.3.1.6 School Curriculum and School Health Education

Maine is one of 38 states in the United States which mandates comprehensive school health education. There is no state-mandated curriculum, however. Through the Maine Department of Education, Division of Curriculum, local schools are provided with technical assistance in developing curriculum. Two school health education consultants in the Department of Education are funded by the Bureau of Health to provide this technical assistance. The responsibility for determining what is taught and how it is taught rests with local communities. At present, the Department of Education has no funds to grant to local educational agencies (LEAs) for local initiatives in comprehensive school health education.

The Department of Education has just been awarded a grant from the U.S. Department of Education under the Secretary's Fund for Innovation in Education Program: Comprehensive School Health Education Program. The Healthy Me/Healthy Maine project is designed to address the problems noted above (and others) by developing and disseminating a model comprehensive school health program for grades K-6. Teacher training is also included in the program. The Division of Health Promotion and Education is collaborating in the development and implementation of the project, which provides a unique channel for dissemination of ASSIST information and programs.

2.3.2 Portland

Portland offers its residents a variety of high quality private and public educational settings. Table II.8 (p. 46) displays the breakdown of the 7,468 students enrolled in Portland's Public School System. The operating cost per pupil in school year 1986-87 was $3,524. Six private secondary schools in Portland have a total enrollment of 1,450. One half of these students attend parochial private schools.

The city has five schools of higher education. Two private junior colleges offer associate degrees. Two private colleges offer both associate and baccalaureate degrees. The University of Southern Maine (USM), Portland campus is one of seven institutions in the state university system. USM has degree programs at the associate, baccalaureate, and graduate level. The total enrollment in all of these institutions is 12,856. Table II.9 (p. 47) shows a breakdown of these numbers by institution.

Portland has one vocational/technical institution. It is operated by the Portland Public School System and served 20 feeder schools. The enrollment is 585.

Table II.8
Portland Public Schools 1989-90 Pupil Enrollment

ELEMENTARY	1986	1987	1988	1989
Jack	568	540	565	571
Peaks Island	62	61	63	62
Hall	392	400	413	405
Lyseth	650	699	602	635
Longfellow	502	523	538	585
Presumpscot	0	0	246	269
Baxter	252	256	203	191
Long Island	20	21	19	16
Cliff Island	7	8	5	9
Riverton	408	435	405	404
Reiche	623	587	567	556
Clifford	342	359	356	337
Total Elementary	3,826	3,889	3,982	4,040
SECONDARY				
Middle Schools				
King	559	469	451	431
Lincoln	570	521	523	538
Moore	494	524	511	459
P.R.E.P.	45	40	39	49
Middle School Alt Pgm	19	0	0	0
Total Middle School	1,687	1,554	1,524	1,477
High Schools				
Portland	1,146	1,075	992	941
Deering	1,292	1,266	1,150	1,010
Total High School	2,438	2,341	2,142	1,951
TOTAL SCHOOL ENROLLMENT	7,951	7,784	7,648	7,468

Source: Maine Department of Educational and Cultural Services, 1989

Table II.9
Total Enrollment in Institutions of Higher Education

	1987-88 ENROLLMENT FULL & PART TIME		
	MALE	FEMALE	TOTAL
PRIVATE SCHOOLS			
Andover College Portland, ME 04103	372	955	1,327
Casco Bay College Portland, ME 04101	66	287	353
Portland School of Art Portland, ME 04101	91	159	250
Saint Joseph's College Windham, ME 04062	233	325	600
Westbrook College Portland, ME 04103			780
PUBLIC SCHOOLS			
University of Southern Maine Portland, ME 04103	3,896	5,650	9,546

Source: Maine Department of Educational and Cultural Services, 1989

The Portland public school system is heavily influenced by its employee unions. Of the system's 1,400 employees, only 35 are not represented by a union.

The union structure is as follows:

- Portland Teachers' Association - (part of National Education Association) represents 600 teachers
- Teacher's Aides & Assistance - represents 100 blue collar workers
- Benefit Association of School Employees - represents 350 blue collar workers
- Classified - represents 10 first line supervisors (quasi-blue collar)
- Portland Administrative Employees Association - represents 10 first line supervisors (quasi-blue collar)
- Portland Principal's Association - represents 27 principals
- Adult Basic Learning - represents 10 teachers

2.3.3 Franklin County Area

There are two School Administrative Districts (SADs) and three single town school districts in the area. SAD 9 includes Farmington, New Sharon, Wilton, and Weld. SAD 58 includes Strong, Phillips, Kingfield, and Eustis/Stratton. Jay, Livermore Falls, and Rangeley are single town school districts. Table II.10 (p.49) lists the school populations by town (where schools exist).

Although each school district is required by state law to have a comprehensive K-12 health education curriculum, state inspections occur only every 5 years. This is a recent requirement which has not yet been enforced in the area. Only Jay is currently making a concerted effort at a comprehensive health curriculum with adequate teacher orientation and training. Health education, including tobacco use prevention and associated topics, such as refusal skills does take place, but is largely dependent on the individual teacher's interest.

School board members of each district are elected, usually for a three year term, by their respective towns. Teacher unions exist in all districts. Parent teacher associations exist variably in the districts, but in general, because of apathy and lack of leadership, are not active. Booster activities of band and athletic events currently attract more parent energy and community support.

Table II.10
School Population in Franklin County By Town, 1988

◆ Enrollment

K-8	3622
9-12	1748
TOTAL	5370

Public Schools

	K-8*	9-12
Eustis/Stratton	99	
Farmington	1,322	916
Jay	738	311
Kingfield	228	
New Sharon	209	
Philips	261	
Rangeley	167	73
Strong	203	349
Weld	33	
Wilton	637	
Totals	3,897	1,620
Livermore Falls	606	342

Private Schools

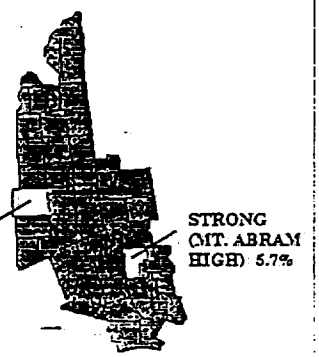
	K-8*	9-12
Kingfield	5	32
Wilton	16	
County Total	21	32

* Includes pre-school if available.

◆ Drop-out Rates

1984-85	2.8%
1985-86	2.8%
1986-87	3.5%
1987-88	2.9%

◆ Schools with Rates Exceeding County Average



◆ Aspirations

Aspirations for Secondary Schooling

1984-85	55.9%
1985-86	54.8%
1986-87	57.5%
1987-88	56.9%

Schools with Lowest Aspiration Rates (5%+ below County Average)

Farmington Strong

Source: Maine Department of Educational and Cultural Services, 1989

Foster Vocational Institute is a regional vocational training institute with 150 students, administrated by SAD 9, but available to students from other school districts.

The University of Maine at Farmington is a 1,700-student branch of the state system. Traditionally a school of education, it has developed other programs such as hotel and ski industry management, and rehabilitation in recent years. The Department of Health Education consists of two professors, currently underutilized as local resources, but very active on the state level. The Health Education major has been certified to allow graduating majors to obtain teaching certificates.

2.4 Major Community Networks

2.4.1 Maine

In this section, we describe the major community networks in which smokers are significantly represented as members or constituents. This section is divided into two parts. The first part discusses larger organizations as examples of channels (some based on coalitions) that reach several target groups: the University of Maine Cooperative Extension and Planned Approach to Community Health (PATCH), among others. The second part includes both large and small organizations that serve as channels specific to each target group.

It should be noted that many of the channels described here have a central or statewide office. Policies, activities, and priorities are determined locally. These channels will be good resources for promoting media statewide, while local chapters or councils will be more suitable for specific activities. Additionally, channels selected may provide indirect as well as direct access to target groups; for example, a civic organization for employers may further reach members' blue collar employees through messages relayed to the worksites.

Maine has historically organized through local groups, in part because of the nature of its fairly widely dispersed population. Because of this, discussion of community networks on a statewide level can be only superficial at best, and to a great extent discussion is limited to a noninclusive listing. The diversity of formalized community networks and their willingness to participate in ASSIST is in Section VI. Attempts to describe non-formalized community networks at a statewide level are difficult. Each town has its own array of groups with goals specific to its people. A more specific description of community networks is provided for each intervention site, below.

2.4.1.1 Cooperative Extension

A key organization that reaches a variety of target groups directly and indirectly is the University of Maine Cooperative Extension (UMCE). UMCE serves all citizens of Maine. Its goal, as one of the largest public outreach programs is to improve lives through the dissemination and application of research-based information. Last year approximately 500,000 direct contacts were made through program participation and information requests. Many programs are targeted specifically to high smoking risk groups - for instance, youth.

UMCE is an educational network connecting state level administrators, program leaders and area specialists with individual county Extension Educators. These Educators work with their county residents to identify priority concerns and develop programs. County Extension Associations are the local connection between UMCE and the people it serves. Extension's federal link is the U.S. Department of Agriculture, which provides partial funding.

An Extension framework requires the support of a land grant institution; in this case, UMCE's is backed by the University of Maine. The University supports Extension programs and research. Campus-based Extension faculty, specialists with expertise in specific areas, work with the 16 county Extension offices (each with extension educators) and the constituents they serve. County Extension agents are linked to the state office by the Field Operations Coordinator.

The Extension specialists are organizationally grouped into four divisions, each under the direction of a program leader, as follows:

- Agriculture and business management
- Family living
- 4-H
- Natural resources and community development

Occupying center stage in UMCE are the citizens for whom Extension develops and initiates programming. Because Extension is managed on a local, county-by-county basis, it delivers programs that address the concerns of the people it serves. To isolate those issues crucial to Maine residents, Extension agents utilize County Extension Associations (constituencies which are broadly representative of the geographic, social, ethnic, and economic aspects of the county of which they are a part).

Historically, UMCE has worked with the Division of Health Promotion and Education on a number of health-related projects including PATCH, Community Chronic Disease Prevention Programs (CCDPP), and Project LEAN via UMCE's Family Living Program's Nutrition and Health Implementation Team. However, as noted in the preceding paragraph, each county association determines its own priorities and level of participation in these activities.

2.4.1.2 PATCH

PATCH provides a forum through which health education professionals and citizens plan, conduct and evaluate health promotion programs at the community level. Working as a team, representatives from the Bureau of Health, Division of Health Promotion and Education, local health agencies, community workers, citizens, and staff from the Centers for Disease Control form an active partnership with the intent of implementing health promotion programs designed to meet the priority health needs of a community. There are currently five PATCH sites in the state: Mount Desert Island; Greater Waterville; Baldwin, Limington, Sebago, and Standish area; St. John Valley; and Ellsworth.

2.4.1.3 Project LEAN Maine Partners Network

Project LEAN is a statewide coalition of over 60 individuals and health-related agencies formed to coordinate with the national Project LEAN activities. Project LEAN, co-sponsored by the Henry J. Kaiser Family Foundation and the Partners for Better Health, is a national public education campaign to reduce cardiovascular disease and cancer by reducing dietary fat consumption.

2.4.1.4 Maine Prevention Network (MPN)

MPN is a statewide coalition of 25 organizations and individuals committed to the concept of primary prevention. MPN provides a resource directory, workshops, information, and technical assistance concerning Maine prevention activities.

2.4.1.5 Katahdin Area Health Education Center (KAHEC)

KAHEC is a federal/educational training program to address the health needs of Maine's rural multicultural population through recruitment, education, and retention of health service providers (especially from target populations). This Area Health Education Center is unique in focusing on strategies to develop culturally appropriate community-based mechanisms for the extension and channeling of health user needs. This is not only to affect the populations (Native Americans and Franco-Americans), but the health care training and delivery systems as well.

2.4.1.6 Voluntary Health Organizations

The American Cancer Society, Maine Division, Inc., American Lung Association of Maine and American Heart Association, Maine Affiliate are important channels. These organizations each have a statewide volunteer network. Each organization is active in tobacco prevention and control. The American Cancer Society, Maine Division, Inc., is described in Section VIII, Voluntary Health Agency Qualifications.

2.4.1.7 Service Organizations

The Lions, Kiwanis, Jaycees, Elks, Key Club and their auxiliaries are important channels to reach a wide range of citizens. These organizations have demonstrated an interest in health promotion activities in the past through their participation in PATCH and activities sponsored by voluntary health organizations. Rotaries participated in health risk appraisals and cholesterol and blood pressure screenings on Mt. Desert Island and in Bangor.

2.4.1.8 Religious Organizations

The Christian Civic League and Maine Council of Churches are active in community networks and in political advocacy. The Christian Civic League was active in the Coalition on Smoking OR Health's 1989 legislative initiative on sale of tobacco to minors. Both groups get involved in a wide variety of legislative, electoral and referenda politics.

2.4.1.9 Libraries

Of the approximate 443 libraries in the state; 235 public, 117 special, 52 health science, 28 post-secondary, 9 institutional, 2 law and legislative libraries, almost all belong to one or more of the following associations that have active memberships.

The American Library Association (ALA) and the Maine Library Association (MLA) promote and improve library services and establish standards of service, support, and education. They also safeguard the professional status of librarians and work as liaisons with federal and state agencies to initiate and administer library legislature.

The public and academic libraries create the largest numbers of ALA and/or MLA members. For the most part, these libraries have a general focus and the concentration of services is toward circulation and reference.

The Medical Library Association (MLA), North Atlantic Health Sciences Libraries (NAHSL), and the Health Science Library and Information Consortium, Inc. (HSLIC) work together. Members of these associations are engaged in professional library of bibliographic work in medical and allied scientific libraries, although some academic libraries are among the membership.

The international Special Library Association (SLA) has a membership of professionals who work in special libraries servicing business, research, universities, newspaper, museums and institutions that use or produce specialized information. Special library is defined as a service unit within an organization having non-library activities. SLA provides consultation services, continuing education sources, an employment clearinghouse, and scholarships.

2.4.1.10 Channels

In addition to the organizations mentioned above, there are numerous community networks specific to each target group:

- Youth - Channels for this group include Boys/Girls Clubs, YMCA, YWCA, 4H, churches, vocational schools, schools (elementary, secondary), government job training programs, Little League and other youth sports leagues, Boy/Girl Scouts, Big Brother/Sister, Family Planning, Coalition for Maine's Children, Office of Truancy, Dropout and Alternative Education.

- Ethnic minorities - The Franco-American Center at the University of Maine publishes a bilingual newspaper and has an advisory board comprised of Franco-American leaders from throughout the state. There are also ethnic social clubs such as Le Club Calumet. Native Americans can be reached via Tribal Councils and health centers especially for the Penobscot and Passamaquoddy tribes. Catholic organizations such as Knights of Columbus and the Catholic Church are channels for Franco- Americans and Native Americans. Additional groups include National Association for the Advancement of Colored Persons and Black Education and Cultural History, Inc.

- Women - Channels for this group include: WIC (Women, Infants, and Children), ASPIRE (Department of Human Services/Department of Labor sponsored work transition program), Aid to Families with Dependent Children, displaced homemakers, job-training programs, Family Planning, churches, Weight Watchers, Lionesses, and the Maine Women's Lobby.

- Blue Collar Workers - Channels for this group include: the Maine State Employees Association, the Maine Labor Group on Health, Maine Municipal Association, Bureau of Employment and Training Program, Displaced Homemakers, Maine Snowmobile Association, and other sporting recreational groups. A number of groups representing specific occupations and industries exist such as the Maine Forest Products Council, and the Maine Paperworkers Association.

- Unemployed - Job training programs, the Department of Education and the Maine Job Service include services to reach unemployed workers.

- Low Income - There are numerous advocacy groups, action councils and neighborhood associations representing low income citizens. These include: We Who Care, Maine AFDC Advisory Council, Maine Association of Interdependent Neighborhoods (M.A.I.N.) among others.

2.4.2 Portland

Portland has a strong network of seventeen neighborhood and civic organizations that represent each resident in the City of Portland, including those that reside on islands. One of these neighborhood organizations, the Portland West Neighborhood Council (PWNC) is the lead organization for one of the Division of Health Promotion and Education's Community Chronic Disease Prevention Project sites. The Director of Portland's Public Health Division is a member of the Health Advisory Committee for this project. Additional organizations include V.F.W.'s, Elks, Eagles, American Legions among others. The Cooperative Extension Service provides an array of services. The Refugee Resettlement Center is the entry point for all refugees relocating to Portland. Voluntary health organizations all have local chapters servicing the Portland area, including the American Cancer Society, American Lung Association, American Heart Association, and Arthritis Foundation.

Participation in church-related activities is high in Portland. There are 59 structural places of worship within the city. A very broad range of denominations is represented.

Because of Portland's enjoyable climate and layout, the city is home to eight major annual festivals. In addition, a myriad of small neighborhood events are held throughout the city each year.

Portland supports a large main public library with four branches. The Portland Public Library's HealthShare Program encourages people to take care of their health and cope effectively with disease by providing them with information resources that will help them make informed choices and decisions.

In 1986, ten percent of all library reference questions and nonfiction book circulation were health related. A major grant was awarded the library to respond to the growing consumer demand for free, current health information. This resulted in the purchase of 2,700 new books, periodicals, video, and audio tapes. A successful campaign was held to make the public aware of these resources at the library. A community directory was published, free health information programs were offered and an arcade was setup in the browsing area of the library. The arcade is a high technology, hands-on, interactive health learning center.

2.4.3 Franklin County Area

The area supports many of the traditional means of community network. Service organizations include Lions, Kiwanis, and Elks as well as several women's groups. There is an active downtown business association in Farmington which holds regular meetings for local merchants. Church congregations and affiliated groups provide individuals with another opportunity for fellowship.

Cultural activities are frequently supported by the university. Events are usually open to the public. The Franklin County Fair is another popular event in the area. This week long agricultural event provides local residents with another means to network.

2.5 Overall Community Environment

2.5.1 Maine

Maine is extremely typical of the New England philosophy of independence, ingenuity and local control. A sense of efficacy for problem solving pervades local communities. Due to the beautiful natural surroundings in Maine, its citizens are environmentally conscious. This consciousness will be a supporting factor for any initiatives regarding involuntary smoking of environmental tobacco smoke. The major geopolitical designation in Maine is the town. Towns are governed through boards of selectmen. Each town has an annual town meeting in which the budget and town warrants are passed. The selectmen, planning boards, school boards, and other committees meet throughout the year. However, with local independence occasionally comes a resentment of state passed legislation which has the potential of making tobacco related legislation difficult at times to pass.

Due in large part to the successes of the Coalition on Smoking OR Health and the work of the Governor's Commission on Smoking OR Health, R.J. Reynolds Tobacco Company has organized a number of "smokers rights" groups in Maine. Professional organizers from out of state have organized at least four local chapters. These groups have been organized since 1989 and have, at times, obscured the scientific/public health basis of the debate. Several newspapers have published editorials against this activity. However, every news article on tobacco control published since these groups were formed includes a quote from one of their representatives.

Maine's tobacco control legislation, as described in Section IV has helped to create an environment supportive of nonsmoking. There is no smoking allowed in a number of public settings and worksites must have policies guaranteed to protect workers from the detrimental health effects of tobacco.

A number of statewide "magnet events" such as the Great American Smokeout, NonDependence Day, and Quit and Win contests promote nonsmoking or cessation. The media, in general, has been supportive and at times assertive in urging the state to go further to restrict tobacco use. The editorial writers of Maine's major newspapers are generally quite supportive of tobacco control.

Outdoor billboards are illegal in Maine, thus eliminating an advertising medium widely used by tobacco companies. However, a number of sporting and cultural events held in Maine are sponsored by tobacco companies. The Oxford Plains Raceway in Oxford, Maine holds auto races which are often sponsored by tobacco companies. Sugarloaf Mountain has held ski races sponsored by tobacco companies. Music tours sponsored by tobacco companies have held performances in Maine venues. There are a large number of agricultural and cultural fairs held throughout the summer in Maine. The fair's patrons are often typical of population groups targeted for marketing by tobacco companies.

There is tremendous potential to increase nonsmoking cues and decrease smoking cues through a variety of channels. The Coalition on Smoking OR Health has learned over time that the issue of protection of children is helpful in promoting tobacco control legislation.

2.5.2 Portland

Portland boasts amenities of cities many times its size with theaters and restaurants, the historical Old Port Exchange, an active waterfront, a civic center, colleges, the university, a vocational school, a new art museum, an international airport, major medical facilities, and media. Yet, Portland still preserves a small town flavor with country and coastal living. Additionally, there is a low crime rate.

Portland serves as the cultural and entertainment center of Maine. Not to be overlooked as one views this city's environment is the influence of its rich history. Portland has three movie theatres with a total seating capacity of 1,375.

Portlanders enjoy a wide variety of health and fitness opportunities. There are eight centers in town that offer all levels of health instruction. Sporting events held at the Civic Center include ice hockey and regional field team visits from other leagues. Portland does not have a major league professional athletic team; however, there is a great deal of local sports activity through the educational systems (e.g. ball clubs, ski, and track clubs).

The potential to influence smoking and nonsmoking messages through the media is great. Portland has a corporate presence for the three major networks: NBC, CBS and ABC. In addition operations for PBS and an independent cable network are in Portland. There are eleven radio stations with a corporate presence in Portland. The area is served by at least 36 radio stations. Guy Gannett Publishers, the largest newspaper printer in the state, is located in Portland. There are three daily newspapers and one weekend paper published in

Portland: Portland Press Herald - circulation 64,000; Portland Evening Express - circulation 29,000; Portland Business Journal - circulation 10,000; Maine Sunday Telegram - circulation 150,000.

Many of the neighborhood associations publish newspapers for their residents. There are at least six in circulation currently.

There are no billboards in Portland; however, there is access to bus advertising through the public transportation system. Bus advertising has not included cigarettes for a number of years, due to the preference of the current advertising coordinator and the lack of frames of sufficient size for most cigarette ads on the buses. However, there is no written policy regarding cigarette advertising on buses.

2.5.3 Franklin County Area

Local media consists of one radio station in Farmington; two biweekly local newspapers (one in Farmington and one in Livermore), and local interest sections in each of the major daily newspapers originating in Waterville and Lewiston, the latter of which is more widely read. Television viewing includes cable in town areas. There are four television stations which are received locally. Two originate in Portland, one in Bangor, and a public television station in Lewiston. Current smoking-related media activities are largely limited to major network PSAs.